Client ID: _____

Case Management Intake/Assessment Instructions

Fields indicated with an asterisk (*) are required to be entered in *PE*. See intake instructions on how/where to enter in *PE*.

_____	_____	_____	_____
***Date**	***Case Manager**	***Location of Assessment**	***Agency assigned Client ID**

Document Intake and Client Status Information

- *Once client has been registered, Open client profile record in PE.*
- *Click "View (drop-down arrow on the right)", "Client Service Profiles".*
- *Double click on the profile for your organization to view it (status should be open).*
- *Put the document into edit mode by clicking "Edit" at the top.*
- *Under the "Main" tab you can add the agency assigned ID by simply typing it in.*
- *Click the "Change Status, Service Level, or Acuity" button to mark the client as "Open" in your agency if this has not already been done.*
- *This button will also allow you to set the client's service or acuity level if your agency uses that.*
- *Next go to the "Intake" tab and select the provider name for the case manager who completed the client's intake by clicking the box on the right side of the field.*
- *Also, put in the date the intake was completed and select the intake location.*
- *Once this is entered, close the document and save changes.*

.

Create Provider Record

To create a provider record for the assigned case manager and medical provider:

- *From within the client profile, click "Create Sub Record (drop- down arrow on the right)" and select "Provider Relationship".*
- *Select the provider name (clicking the box on the right side of the field) from the list and select the provider relationship (also using the box on the right side of the field).*
- *Select "HIV Case Manager" as the relationship type for the client's assigned case manager.*
- *Enter in the relationship start date, then close and save the record.*
- *Enter the Medical Provider in the same way as Case Manager. Use the relationship type that best fits.*
- *Other relationships can be added/created as your agency deems necessary.*

If others present:
Name: _____ Relationship to client: _____ Phone: _____

Client Information

For all of the data entry *for the remainder of the form, you will open the client profile in PE, place it into Edit mode by clicking the "Edit" button at the top, and work from within that record.*

***Legal Name:** _____
First Middle Last Preferred

***SSN:** _____/_____/_____ ***DOB:** _____ ***Gender:** ☐ Male ☐ Female ☐ Transgendered

Name(s), Gender, DOB and SSN can all be entered under the "Profile" tab. You can simply type in the information for name, DOB and SSN. For gender, you must select the correct information for the client by using the drop-down arrow on the right side of the field. Some of this information may already be in the record from the client registration process, but you can change it from here if needed.

***Current Street Address:** _____ ***Date Moved In**: _____

*** City: _____*County: _____ *State_____ * Zip _____**

Client ID: _____

Street Address and Date moved in are entered under the "Address" tab. The date moved in is the same as "Date effective" in this record. Type in the date effective, street address, and zip code into the corresponding fields. Use the drop-down arrows to select the appropriate city, county, and state. (Note: If Date Moved in is not known by Client, enter date as January 01 of estimated year.)

***Housing Type**: *Under the "Address" tab. Use the drop-down arrow on the right side of the field to select the appropriate number/category.*

- ☐ 01-Emergency Shelter
- ☐ 02-Transitional Housing/formerly homeless
- ☐ 03-Permanent Housing/formerly homeless
- ☐ 04-Psychiatric Hospital/facility
- ☐ 05-SA Tx/Detox facility
- ☐ 06-Hospital, non-psychiatric
- ☐ 07-Jail/Prison/Juv. Detention
- ☐ 08-Don't Know
- ☐ 09-Refused
- ☐ 10-Room/Apt/House that is Rented
- ☐ 11-Apt/House/Mobile Home that is Owned
- ☐ 12-Living in a Family Member's home/apt/room
- ☐ 13-Living in a Friend's home/apt/room
- ☐ 14-Hotel/Motel, not paid by emergency voucher
- ☐ 15-Foster Care/Foster Group Home
- ☐ 16-Streets/Living in a place not meant for Habitation
- ☐ 17-Nursing Home
- ☐ 17-Other:_____

***Rent/Own:** *Under the "Address" tab. Use the drop-down arrow on the right side of the field to select the appropriate category.*

☐ Rent ☐ Own ☐ Unknown ☐ Does not contribute

***OK to do home visit?** *Under the "Mail" tab. Use the drop-down arrow on the right side of the field to select the appropriate category.*

☐ Yes ☐ No

*** Current Housing Programs**: *Under the "Address" tab. Select the current housing program(s) for the client from the matching list in PE.*

☐ HOPWA ☐ HUD ☐ Public Housing ☐ Section 8 ☐ TBRA ☐ None

***Mailing address/PO Box:** *Under the "Mail" tab. In the field "Mailing Address Line 1" you can click the button on the right side of the field to carry over the client's name and street address from the profile and address tabs. If the client's mailing address and street address are the same, then you will not need to change anything. **IF** mailing address is **different** from the street address, then you simply type in the correct information into the fields "Mailing Address Lines 2, 3, (&4 if needed)"to replace the street address that was carried over.*

***OK to send mail?** ☐ Yes ☐ No *Under the "Mail" tab. Use the drop-down arrow on the right side of the field to select the appropriate category.*

Email address: *Under the "Mail" tab. This field will appear only if you select that it is ok to send email. Then you simply type in the client's email address.*

OK to send email? ☐ Yes ☐ No *Under the "Mail" tab. Use the drop-down arrow on the right side of the field to select the appropriate category.*

***Home Phone:** *Under the "Phone" tab. Type in the client's phone number. However, if the client has no phone, then the word "none" has to be entered into this field since it is required to be filled in with something.*

***Message?** *Under the "Phone" tab. Use the drop-down arrow on the right side of the field to select the appropriate category.*

☐ None ☐ Any ☐ Discreet ☐ Name Only

Other (Work/Cell) Phone: *Under the "Phone" tab. Type in the client's phone number into the appropriate field (either work or other).*

Message? *Under the "Phone" tab. Use the drop-down arrow on the right side of the field to select the appropriate category.*

☐ None ☐ Any ☐ Discreet ☐ Name Only

Citizenship: *Under the "Demo" tab. Use the drop-down arrow on the right side of the field to select "yes" or "no" as to whether the client is a US citizen or not.*
☐ US ☐ Other (specify):_____

***Race (All identified with):** *Under the "Demo" tab. Select all races that the client identifies with from the matching list in PE. (Note: This question is client self-report. Each CM must ask client for this information.)*
☐ White ☐ Black ☐ Asian ☐Native American ☐Native Hawaiian ☐ Alaskan ☐ Pacific Islander ☐ Other
☐ Refused to Report ☐ Unknown

***Ethnicity:** *Under the "Demo" tab. Use the drop-down arrow on the right side of the field to select the appropriate category.*
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

Veteran: ☐ Yes ☐ No *Under the "Demo" tab. Use the drop-down arrow on the right side of the field to select the appropriate category.*

If yes, is CL eligible for VA benefits? ☐ Yes ☐ No

***Marital Status:** *Under the "Demo" tab. Use the drop-down arrow on the right side of the field to select the appropriate category.*
☐ Divorced ☐ Married ☐ Partnered ☐ Separated ☐ Single ☐ Widowed ☐ Unknown

***Primary Language:** *Under the "Demo" tab. Use the drop-down arrow on the right side of the field to select the appropriate category.*
☐ English ☐ Spanish ☐ Sign ☐ Other: _____ Will the client need translation services? ☐ Yes ☐ No

***Reading Ability/Literacy:** *Under the "Education" tab. Use the drop-down arrow on the right side of the field to select the appropriate category. Note: you can only select "yes", "no", or "limited"*
☐ No ☐ Yes, ☐ High ☐ Moderate ☐ Limited

Education Level: *Under the "Education" tab. Use the drop-down arrow on the right side of the field to select the appropriate number/category.*
☐00- No Schooling ☐01- ≤ 4th grd ☐02- 5th or 6th grd. ☐03- 7th or 8th grd.
☐04- 9th grd. ☐05- 10th grd. ☐06- 11th grd. ☐07- 12th grd., no diploma
☐08- High School Diploma ☐09- GED
☐10- Educational Degree beyond HS diploma (Circle app. level: Associate degree; Graduate degree; Undergraduate degree; post-secondary school; Technical/Trade/Vocational degree)

*Household Members
Complete in full: All information is required for RW and HOPWA programs

Under the "Household" tab. Go to the bottom of this record and add the contact records/household members first. To do this, you click on the "Add" button. This will open up a contact record where you will enter in the data from this section as it relates to the fields in PE. A separate contact record has to be added for each member of the household. If you need to edit an existing contact record's information or change the status to "inactive" then double click on the contact member's name listed in the box near the bottom of the page.

It is important that you understand that "household member" may be different than "HOPWA household member". Household member will be included in the household poverty level used for the RW RDR whereas the HOPWA household member field is not. It is OK for a contact to be a HOPWA household member and NOT be

a household member. Typically a household member is defined as a spouse, child, or dependent of the client and HOPWA household member may simply be a relative that the client lives with, a partner, or a roommate (not counted on their taxes)whom the client shares housing expenses/income with. If the client contact is actually listed as a "household member" then it is important that you put in some income amount for them if you can- even if it is a best estimate from the client. If not, then it looks like the client is supporting that entire household solely on his/her income and it appears that the household is at a higher poverty level than they actually might be. After all data is entered for the contact/household member, <u>close</u> and <u>save</u> the record.

Once all the contact/household members have been added (or edited) click on the "<u>Total Household Size</u>" button that is blue so that it automatically populates the information for this field. It is important to do this <u>even if the client is living alone</u> and has no contact records to be added so that the household size is captured as "1". All other fields in this record will be automatically updated when this button is clicked.

____________________ ____________________ ____________________
Contact First Name **Contact Last Name** **Relationship to Client**

OK to Contact? ☐Yes ☐ No
Emergency Contact? ☐ Yes ☐ No
Dependent? ☐ Yes ☐ No
Household Member? ☐ Yes ☐ No
HOPWA Household Member? ☐ Yes ☐ No
Aware of CL Status? ☐ Yes ☐ No
Date of Birth: ____________________
Gender: ☐ Male ☐ Female ☐ Transgendered

Race (All Identified With): ____________________
Ethnicity: ☐ Hispanic ☐ Non-Hispanic
Monthly Income: ____________________
HIV/AIDS Status: ☐ AIDS ☐ Negative ☐HIV+, Status Unknown ☐ HIV+, not AIDS ☐ Indeterminate ☐ Unknown
Phone Number: ____________________
Msg. Type: ☐ None ☐ Any ☐ Discreet ☐ Name Only

____________________ ____________________ ____________________
Contact First Name **Contact Last Name** **Relationship to Client**

OK to Contact? ☐Yes ☐ No
Emergency Contact? ☐ Yes ☐ No
Dependent? ☐ Yes ☐ No
Household Member? ☐ Yes ☐ No
HOPWA Household Member? ☐ Yes ☐ No
Aware of CL Status? ☐ Yes ☐ No
Date of Birth: ____________________
Gender: ☐ Male ☐ Female ☐ Transgendered

Race (All Identified With): ____________________
Ethnicity: ☐ Hispanic ☐ Non-Hispanic
Monthly Income: ____________________
HIV/AIDS Status: ☐ AIDS ☐ Negative ☐HIV+, Status Unknown ☐ HIV+, not AIDS ☐ Indeterminate ☐ Unknown
Phone Number: ____________________
Msg. Type: ☐ None ☐ Any ☐ Discreet ☐ Name Only

____________________ ____________________ ____________________
Contact First Name **Contact Last Name** **Relationship to Client**

OK to Contact? ☐Yes ☐ No
Emergency Contact? ☐ Yes ☐ No
Dependent? ☐ Yes ☐ No
Household Member? ☐ Yes ☐ No
HOPWA Household Member? ☐ Yes ☐ No
Aware of CL Status? ☐ Yes ☐ No
Date of Birth: ____________________
Gender: ☐ Male ☐ Female ☐ Transgendered

Race (All Identified With): ____________________
Ethnicity: ☐ Hispanic ☐ Non-Hispanic
Monthly Income: ____________________
HIV/AIDS Status: ☐ AIDS ☐ Negative ☐HIV+, Status Unknown ☐ HIV+, not AIDS ☐ Indeterminate ☐ Unknown
Phone Number: ____________________
Msg. Type: ☐ None ☐ Any ☐ Discreet ☐ Name Only

____________________ ____________________ ____________________
Contact First Name **Contact Last Name** **Relationship to Client**

OK to Contact? ☐Yes ☐ No
Emergency Contact? ☐ Yes ☐ No

Race (All Identified With): ____________________
Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Client ID: _____

Dependent? ☐ Yes ☐ No
Household Member? ☐ Yes ☐ No
HOPWA Household Member? ☐ Yes ☐ No
Aware of CL Status? ☐ Yes ☐ No
Date of Birth: _____
Gender: ☐ Male ☐ Female ☐ Transgendered

Monthly Income: _____
HIV/AIDS Status: ☐ AIDS ☐ Negative ☐HIV+, Status Unknown
☐ HIV+, not AIDS ☐ Indeterminate ☐ Unknown
Phone Number: _____
Msg. Type: ☐ None ☐ Any ☐ Discreet ☐ Name Only

Employment and Transportation

Current Employment Status: *Under the "Finances" tab, then go to the "Employment" sub-tab. Use the drop-down arrow on the right side of the field to select the appropriate category.*

☐ ≥ 35 hrs per week ☐ < 35 hrs per week ☐ Unemployed/Not Disabled ☐Temp Disabled ☐ Perm Disabled ☐ Retired

***Transportation:**

Does client have access to transportation? *Under the "Finances" tab, then go to the "Employment" sub-tab. Use the drop-down arrow on the right side of the field to select the appropriate category.*

☐ Yes ☐ No

If yes, please list primary transportation type: *Under the "Finances" tab, then go to the "Employment" sub-tab. Use the drop-down arrow on the right side of the field to select the appropriate category.*

☐ Bus ☐ Cab ☐ Family Member ☐ Leases Car ☐ Medicaid Van ☐ Owns Car ☐ Other: _____

Finances

****Verification of income is required for all services: HOPWA, RW, & ADAP services**** See ADAP Program Guidelines for acceptable forms of income documentation.

*Source of Income	Received From	$ Client	$ Household/Other
Earned Income/Employment			
Unemployment			
SS-Retirement			
SSI			
SSDI			
Private Disability			
Veteran's Pension			
VA Disability Payment			
TANF/AFDC			
General Assistance (GA)			
Workers Comp			
Former Job Pension			
Child Support			
Alimony or Spousal Support			
Food Stamps			
Other			

Under the "Finances" tab, then go to the "Income" sub-tab. Type in the client's income information into the matching fields within PE. ***For Household Income*** *(the last field on the page) you will notice that it is written in blue. To enter in the household income, you truly need to have put that income into the contact record under the "Household" tab. Once the information is in the contact record, you simply click on the blue wording and the field is automatically populated with the information from that previous tab. Note: If the client has zero income, then you also need to go to the "Income Totals" sub-tab under "Finances" and fill in the confirmed zero income field as "yes". This may not mean that you have verification of that zero income yet, but that you are stating it is true that the client has zero income at this time.*

Expense Type	Paid To	$ Client	$ Household Other
Rent/Mortgage			
Electricity/Gas			

Water			
Phone			
Cable			
Transportation (Gas, etc.)			
Food			
Child Care			
Car Payment			
Home Owners			
Renter's Insurance			
Property Taxes			
Car Insurance			
Credit Cards/Loans			
Unreimbursed Medical Expenses			
Child Support			
Health Insurance			
Other			

Under the "Finances" tab, then go to the "Expense" sub-tab. Type in the client's income information into the matching fields within PE.

***Total Monthly Income**	
Total Monthly Expenses	
Total Monthly Cash Flow	

***Area for Median Income:** *Under the "Finances" tab, then go to the "Income Totals" sub-tab. Click on the box on the right side of the field to select the appropriate area for the client.*
☐ Charlotte/Gastonia/Concord ☐ Chester Co. ☐ Lancaster Co.

Other Financial Information/Needs:_____

Medical Information

HIV STATUS (Self Report)

***Date HIV Diagnosis:** *Under the "Medical" tab. Type in the date in the corresponding field.*
***Date of AIDS Diagnosis (if applicable):** *Under the "Medical" tab. Type in the date in the corresponding field. This field will only show if the disease stage indicates AIDS.*

***Current Stage of Disease:** *Under the "Medical" tab. Use the drop-down arrow on the right side of the field to select the appropriate category.*
___AIDS ___HIV +, AIDS Status Unknown ___HIV+, Not AIDS ___Indeterminate

***How do you think you got infected? (List all Possible Transmission Routes)** *Under the "Medical" tab. Select all possible transmission routes for the client from the matching list in PE.*
☐ Blood Transfusion ☐ Exposure to Blood ☐ Hemophilia ☐ Heterosexual Contact ☐IV Drug Use
☐ Man Who has Sex with Men (MSM) ☐ Perinatal ☐ Other ☐ Undetermined ☐ Refused to Report

Primary Care Provider: _____ **Infectious Disease Physician: _____**

***Primary Care Source:** *Under the "Medical" tab. Use the drop-down arrow on the right side of the field to select the appropriate category.*
☐ Other Public Clinic ☐ Outpatient Clinic (Hospital) ☐ Public Comm. Health Center
☐ RW Title III Clinic ☐ RW Title II Clinic ☐Solo/Group Practice ☐ Unknown ☐ VA or Military Hospital

***Most recent CD4:** ***Most recent viral load:** ***Date of lab results:** *Note: This information needs to be entered into PE only if your agency pays for or provides ambulatory/outpatient medical services for the client. However, entering CD4 and Viral Load is recommended for all sites.*

Client ID: _____

Instructions are for manual data entry and not for agencies using the lab import system. You also need to get this information from a physician or lab print out.
Click "Create Activity" and then select "Test Result". Select the appropriate test name by clicking on the box in the lower right corner of the field (CD4 Count or HIV1 Viral Load). Enter in the date for the test in the appropriate field and the result will go in the "Numeric value" field. The numeric value field will not appear until you select the test name. Leave the test modifier alone for CD4 count (it should be equal to the result) and change it to be < or > for the viral load result (depending on the result value). Then close and save the record.

***How do you rate your overall health?** *Under the "Medical" tab in the "General Health Status" field. Use the drop-down arrow on the right side of the field to select the appropriate category.*
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Don't Know

MEDICATIONS/TREATMENT ADHERENCE

*Current Medication Name	*Date Started	*Antiretroviral? (Y/N)	*Condition Treated	Pharmacy used for this med
1.				
2.				
3.				
4.				
5.				
6.				
7.				

To enter in medications for the client: Click "Create Activity" and select "Drug". Once in the drug record, change the status to "active" or "inactive" as appropriate; Enter in the date for when the client started the medication (or when the drug record became active/inactive). Select the drug name from the drug list by clicking on the box in the lower right corner of the field. Enter in the dosing and strength if you know this information. Then indicate the Reason why the medication was prescribed in the "Reason Prescribed" field by using the drop-down arrow on the right side of the field.

***How many antiretroviral meds is the client currently on?** *Under the "Medical" tab in the "Antiretroviral Therapy" field". Use the drop-down arrow on the right side of the field to select the appropriate category.*
☐ > 4 ☐ None ☐ 1 ☐ 3 or 4 ☐ 2 ☐ Unknown

***Date antiretroviral therapy was started:** *Under the "Medical" tab. Type in the date therapy was started. This field will only show if the client has 1 or more antiretroviral meds indicated in the "antiretroviral therapy" field.*
***Is CL on HAART?** ☐ Yes ☐ No *Under the "Medical" tab. Use the drop-down arrow on the right side of the field to select as "yes" or "no". This field will only show if the client has 3 or more antiretroviral meds indicated in the "antiretroviral therapy" field.*
* **Is therapy Salvage?** *Under the "Medical" tab. Use the drop-down arrow on the right side of the field to select as "yes" or "no". This field will only show if the client has 3 or more antiretroviral meds indicated in the "antiretroviral therapy" field.*
☐ Yes ☐ No (Salvage therapy will need confirmation from CL's physician)

Any drug allergies? ☐ Yes ☐ No **If yes, please list:** _____

Do you have any side effects or problems taking any of your medications? _____
_____

Have you missed any doses of your medications in the last month? If yes, how many and why? _____
_____

Do you have any cultural or religious beliefs/practices that would prevent you from taking medications or accessing medical care? If yes, Please describe: _____
_____

HIV KNOWLEDGE SCREENING

Why are CD4/viral load tests important to your health? _____

How do you feel about coming to the doctor regularly and why this is important for your health? _____
_____

Describe the client's understanding of HIV? _____
_____

NOTE: Be sure to assess/discuss HIV transmission factors in the risk assessment section to meet the full HIV knowledge screening requirement.

MEDICAL ASSESSMENT

Diagnosed health problems other than HIV (Ex: heart disease, diabetes, blood pressure, TB, etc): _____
_____

***Is the client indicated to have a TB test/PPD completed?** *Note: This information needs to be entered into PE only if your agency pays for or provides ambulatory/outpatient medical services for the client. However, entering TB information is recommended for all sites. A physician will need to advise you on whether or not a client is indicated to have a PPD completed or not.*
Click "Create Activity" and then select "TB Assessment". Enter in the date of the assessment. In the "Clinically Indicated Action" field select which type of procedure is indicated for the client by using the drop-down arrow on the right side of the field. For example, if the client needs to have a PPD completed, then select "PPD". If the client has a history of a positive PPD and no TB testing is indicated for the client then select "No action required". Once PPD is indicated as the action needed, then a field called "PPD Status" will drop down for you to fill in using the drop-down arrow on the right side of the field. Select the appropriate category for the PPD status (if it hasn't been placed yet, then select 'not administered". Then close and save the record.

☐ Yes ☐ No, has a Hx of TB ☐ No, has already completed this yr.
If client has a Hx of TB, was a chest x-ray done? ☐ Yes ☐ No If yes, Date of chest x-ray: _____

***Has client already had a TB test this year?** ☐ Yes ☐ No **If yes, please indicate the date and results**:_____
Note: This information needs to be entered into PE only if your agency pays for or provides ambulatory/outpatient medical services for the client. However, entering TB information is recommended for all sites. You also need to get this information from a physician.
Click "Create Activity" and then select "TB Assessment". Follow the same steps as listed above for documenting a PPD as clinically indicated. However, indicate under the "PPD Status" that the test has been completed. Then you will complete the field of "PPD Result" to document if the PPD was positive, negative, indeterminate, or unknown. PPD Result is entered in by using the drop-down arrow on the right side of this field. Then close and save the record.

*However, if you previously created a TB Assessment to show that a PPD was clinically indicated for the client, you will **NOT** create another TB assessment through "Create Activity" but instead will click "View" activity and edit the existing TB Assessment to show that the PPD has now been placed and enter in the final results.*

***Currently Pregnant?** *Note: This information needs to be entered into PE only if your agency pays for or provides ambulatory/outpatient medical services for the client. However, entering pregnancy information is recommended for all sites.*
Click "Create Activity" and then select "Diagnosis". Then you will select the diagnosis name or code that matches with pregnancy (A039) using the box on the right side of the field. You will indicate that the diagnosis is active in the "Diagnosis Status" field and enter in the date for the diagnosis. Then close and save the record.

You will also need to remember to go back to this diagnosis record and mark it "inactive" once the pregnancy has ended later in the year. The diagnosis record will be located under the activity records for the client. Be sure to indicate the pregnancy results (live birth, miscarriage, etc) when you close the record. If the client has a "Live birth" then you also want to be sure to add that new child in the client's household contact records if the baby is going to be living with the client.

☐ Yes ☐ No ☐ N/A **If yes, expected due date: _____**
Last Pregnancy End Date: _____
Last Pregnancy Outcome: ☐ Elective Abortion ☐ Live Birth ☐ Miscarriage ☐Still Birth

***For female clients: Date and result of last pap smear:** *Note: This information needs to be entered into PE only if your agency pays for or provides ambulatory/outpatient medical services for the client. However, entering pap smear information is recommended for all sites*

Instructions are for manual data entry and not for agencies using the lab import system. You also need to get this information from a physician or lab print out.
Click "Create Activity" and then select "Test Result". Select the appropriate test name by clicking on the box in the lower right corner of the field (Pap smear). Enter in the date for the test and the test result into the "Test Result Keyword" field by clicking the box in the lower right side of the field and then selecting the appropriate result. Leave the test result status as final and the modifier as = if this is the final result for the pap smear. Then close and save the record.
For females over age 40, date of last mammogram: _____

When was the client's last physical completed? _____
*** Immunizations:** *Note: This information needs to be entered into PE only if your agency pays for or provides ambulatory/outpatient medical services for the client. However, entering immunization information is recommended for all sites You also need to get this information from a physician.*
Click "Create Activity" and then select "Vaccination". Then you will select the vaccine/immunizations name by using the drop-down arrow on the right side of the field and enter the date the vaccine was given to the client. Then close and save the record.

Last Tetanus shot_____ Last Flu shot _____Hep B vaccine_____
Pneumovax _____ Other vaccines: _____

History of hospitalizations (When, where, why): _____
_____

HIV-related symptoms experienced: __ Fevers __ Night sweats __ Tiredness __ Weight loss __ Loss of appetite __ Diarrhea __ Thrush __ Short term memory loss __ Yeast infections __ Nausea __ Chills __ Change in vision __ Cold sores ___ None

How do these symptoms and your overall health affect your ability to work and do the things you enjoy?_____
_____

***Opportunistic Conditions: (check all that apply- please indicate if past or current)** *Note: This information needs to be entered into PE only if your agency pays for or provides ambulatory/outpatient medical services for the client. However, entering OI information is recommended for all sites You also need to get this information from a physician. Only current infections need to be entered.*
Click "Create Activity" and then select "Diagnosis". Then you will select the diagnosis name or code that matches with the current infection/condition by using the box on the right side of the field. You will indicate that the diagnosis is active within the "Diagnosis Status" field and enter in the date for the diagnosis. Then close and save the record.

☐ Wasting Syndrome
☐ Cryptococcal
☐ Hepatitis B
☐ Kidney failure
☐ Neuropathy
☐ Bacterial infections
☐ CMV
☐ Invasive cervical cancer
☐ Lymphatic leukemia
☐ Non-Hodgkin's lymphoma
☐ Thrush
☐ Dementia
☐ Vision loss
☐ Meningitis
☐ PCP

☐ Pneumonia ☐ Shingles ☐ Syphilis
☐ Toxoplasmosis ☐ Tuberculosis ☐ Other:_____

VISION/DENTAL/NUTRITION/ADL's/IADL's

When was your last dental check-up? _____ Dental needs now: _____

When was your last eye exam? _____ Vision needs now: _____

How many meals do you eat per day? ____ Is your diet well-balanced/nutritious? ____ Assistance needed with nutrition? ____

Is assistance needed with daily activities (walking, feeding, bathing, grooming, dressing, toileting)? _____
If so, please describe: _____

Is assistance needed with the following activities: housekeeping, shopping, using the phone, medication management, money management)? _____ If so, please describe_____

Risk Assessment

History of sexually transmitted diseases: __ Syphilis __Herpes __Gonorrhea __ Chlamydia __ Genital warts __ None Other:____

***Does the client believe s/he may currently have an STD (Other than HIV)?** ☐ Yes ☐ No **If yes, please specify and refer for treatment if needed or indicate if currently receiving treatment:** *Note: This information needs to be entered into PE only if your agency pays for or provides ambulatory/outpatient medical services for the client. However, entering STD information is recommended for all sites. You also need to get this information from a physician. Only current infections need to be entered.*
Click "Create Activity" and then select "Diagnosis". Then you will select the diagnosis name or code that matches with the current infection/condition by using the box on the right side of the field. You will indicate that the diagnosis is active within the "Diagnosis Status" field and enter in the date for the diagnosis. Then close and save the diagnosis record.
If the condition is being treated then you also want to create a drug record to indicate that the client is receiving medication for the condition. See under the medication table on how to enter in drug records.

_____

Tell me what you know about how to avoid HIV transmission and/or re-infection?
_____
_____

What types of sex have you ever had? ___ Oral ___Anal ___Vaginal

What types of sex do you currently have? ___ Oral ___Anal ___Vaginal ___ None

Do you currently have sex with? ___ Men ___Women ___Both ____NA

How often do you use condoms for sexual activities? _____
What is the client's understanding of how to use male or female condoms and/or dental dams? _____
_____

If IV drug use was a risk factor, was risk reduction related to clean needles and no sharing needles discussed? ☐ Yes ☐ No

In the past, what has kept you from using condoms/protection? ☐Abusive sex partner ☐Cultural barriers ☐Physical abuse ☐Limited cognitive ability ☐Substance Use/Abuse ☐Limited income to purchase protection ☐Low self esteem ☐Mental health issues ☐Unaware of safe practices ☐Partner unwillingness to practice safer sex ☐Client unwillingness to practice safer sex

Has the client notified past/current sexual partners of HIV status? ☐ Yes ☐ No

If no, describe what steps were taken to assist client in this process (such as referral to DIS):_____
_____

Client ID: _____

Legal Documents Status

Document	Needed	In Progress	Completed	Not Needed	Not Interested
Will					
Durable Power of Attorney					
Living Will					
Health Care Power of Attorney					
Guardianship					
Burial Plans					

Legal Problems (indicate legal/criminal history):_____

Remark on any pending legal problems or needs: _____

Housing Assessment

Does the client feel that his/her housing is affordable? ☐ Yes ☐ No
Is the client in danger of losing current housing? ☐ Yes ☐ No **If yes, explain:** _____
Are there any structural or functional inadequacies in the client's home? ☐ Yes ☐ No
If yes, please describe: _____
How does the client feel about his/her current housing arrangements? _____
Other comments regarding housing condition/needs:_____
_____

Substance Use

Identify current or past use of any substances including Alcohol, Amphetamines, Steroids, Chew/Snuff, Cigarettes, Club Drugs, Cocaine, Inhalants, IV Drugs, Hallucinogens, Marijuana, Prescription Drugs, Sedatives, OTC Medications, etc.

☐ **No history of substance use**

Substance	Currently Using?	Date of last use?	Average quantity of use (How much)	Frequency of use (How often)	Age of first use?	Does client identify use as a problem to work on?

Has client ever been in treatment? ☐Yes ☐ No **If yes, when and where?** _____
Does client feel treatment was effective? ☐Yes ☐ No Comments: _____

If currently using, is the client willing to receive a referral to a substance abuse counselor or program? ☐ Yes ☐ No
If no, explain: _____

Mental Health Assessment

Describe what gives your life meaning / Hobbies you enjoy: _____
_____

Stressors: What are the things that worry you? How long have you worried about them? What have you done in the past to help you deal with the stress? _____
_____

What role does spirituality or religion play in your life? _____
_____

Please list all Mental Health issues or disorders (diagnoses) and treatment (for at least the past 10 years, include types of treatment, length of time in treatment, and provider: _____
_____

Have you ever attempted to hurt or kill yourself or others in the past? ☐Yes ☐ No

If yes, describe when and how? _____ _____

In the last month, have you often experienced feelings of sadness or hopelessness? ☐ Yes ☐ No

In the last month, have you experienced a loss of interest in things you like doing? ☐ Yes ☐ No

Have you recently been bothered by thoughts or feelings that people were trying to hurt you? ☐ Yes ☐ No

Have you recently heard, seen, or felt things that no one else could? ☐ Yes ☐ No

Have you ever been a victim of domestic violence (verbal or physical abuse by a partner/spouse/family member)?
☐Yes ☐ No

If yes, are you currently involved in an abusive relationship? ☐Yes ☐ No Comments: _____

CRISIS INTERVENTION

Are you having thoughts or intentions of hurting yourself? ☐ Yes ☐ No

Are you having thoughts or intentions of hurting others? ☐ Yes ☐ No
If yes, whom? _____

If applicable, do you have a plan to carry out your thoughts? ☐ Yes ☐ No
If yes, what is the plan? _____

If applicable, do you have access to weapons or anything else to hurt yourself or others? ☐ Yes ☐ No
Record specifics of what client has access to (i.e. pills, guns, knives, etc.):_____

If necessary, referral made to: _____Phone Number_____
Was an appointment scheduled? ☐ Yes ☐ No **If yes, when:** _____
If no, please comment: _____

MENTAL CONDITION: Document Client's Mental Condition at time of your interview

Behavior ☐Polite ☐Cooperative ☐Suspicious/distrustful ☐Aggressive ☐Hostile ☐Agitated ☐Nervous ☐Withdrawn ☐Uncooperative ☐Resistant

Speech ☐Slow ☐Rapid ☐Pressured ☐Loud ☐Soft ☐Slurred ☐Mumbled ☐Monotone ☐Clear/coherent ☐Confused ☐Stuttering ☐Appropriate Speed and volume

Appearance ☐Neat/ well groomed ☐Unkempt/poor grooming ☐Malodorous (bad smelling) ☐Unusually Dressed ☐Appears older than age ☐appears younger than age ☐not remarkable

Movements ☐Steady gait (good balance) ☐Unsteady gait (poor balance) ☐Tics (involuntary twitches) ☐Fidgety/ agitated ☐Smooth movements ☐Appears stiff or uncomfortable when moves ☐Psychomotor retardation (moves slowly)

Level of Consciousness ☐Alert ☐Drowsy ☐Non-responsive

Attention/Concentration ☐Good concentration/attn. ☐Easily distracted ☐Difficulty following interview/answering questions ☐Unable to complete interview because of inattention

Orientation: ☐Oriented to person ☐Oriented to place ☐Oriented to time ☐Non-Oriented ☐Oriented to person, place, & time

Memory ☐Memory intact ☐Recent memory intact ☐Remote memory intact ☐Neither recent nor remote memory intact

Judgment ☐Clear/logical ☐Irrational ☐Cloudy **Thoughts:** ☐Confused/jumbled ☐Clear/logical

Affect (facial expression) ☐Expression fits mood ☐Expression does not fit mood ☐Flat affect (No variety of expression) ☐Blunt affect (less variety of expression than expected) ☐Full range of affect (full variety of expression)

Client's Emergency Contact: _____ **Phone:** _____
Msg. Type: _____ **Aware of CL's HIV Status?** ☐ Yes ☐ No
Be sure to get a release of information for this person

Needs Assessment (should be reflected on action/service plan)

Client ID: _____

☐Adherence Counseling	☐Housing Assistance	☐Partner Notification	☐ Vision
☐Alcohol/Substance Abuse Treatment	☐ Insurance Premium Asst.	☐Peer Services	
☐ Dental Care	☐Legal Assistance	☐Prescription Assistance	
☐Employment Asst	☐ Medical Care	☐Risk Reduction Education	
☐Emergency Financial Assistance	☐Medical Case Management	☐SSI/SSD	
☐ Financial Counseling	☐Medicaid	☐Support Groups	
☐ Food Bank	☐Medicare	☐Transportation	
☐ Food Stamps	☐Mental Health Counseling	☐Volunteering	

REFERRALS TO BE MADE: *Referrals should be documented in a referral document within PE. This is done by clicking the button "Create Activity" at the top of the client profile record. Then select "Referral" and fill in the referral information for the client. At least a provider or an organization has to be entered in for the referral form. Organizations must be selected from the list and providers can be entered in manually if needed. Once the referral document is complete, you "Submit" the record, close and save it. The record can later be found and edited under the client activity records to allow you to mark if the referral was approved (kept) or rejected (not). Also remember that case managers should follow up on all referrals made within 30 days, so using the "date check back" field can help PE to remind you of this through required actions.*

ALERT MESSAGE IN PROVIDE: *Under the "Profile" tab. Simply type in the alert message in the corresponding field.*

SUMMARY

Summarize assessment information in a concise, coherent manner. You are identifying problems and concerns that became evident during your assessment. Please also include strengths, weaknesses that you have identified in the client.

_____
_____
_____
_____
_____
_____
_____
_____

I, _____, certify that all the information I have given is true and accurate to the best of my knowledge and belief. I agree to provide financial and other verification that may be needed to receive services.

Client or Guardian _____ **Date** _____
Case Manager _____ **Date** _____
***Witness (if needed)** _____ **Date** _____
Supervisor _____ **Date** _____

*** If you do not have a third party witness available when signature is indicated by a mark, please write a note of explanation and get your supervisor to initial and date this form.**

Benefit Assessment Tool

*PRIVATE INSURANCE

Under the "Insurance" tab, then go to the "Private" sub-tab. Use the drop-down arrow on the right side of the field to select the appropriate category to indicate if the client has "active" private insurance benefits. Once listed as active, additional fields will show up to be able to enter the rest of the insurance information. To enter the company name, click on the "Private Carrier" field. Then click on the box on the right side of the field to select the appropriate company name. Type in the ID number in the corresponding field. Use the drop-down arrows to indicate if the client has coverage for Rxs and Mental Health.

Does this client have Private Insurance coverage for?
Medical Care? ☐ Yes ☐No **Prescriptions?** ☐ Yes ☐ No **HIV Meds**? ☐ Yes ☐ No **Mental Health?** ☐ Yes ☐ No

If for prescriptions only, is this a Medicare Part D Plan? *If the insurance company listed here is actually for Medicare Part D, then you want to enter that in differently and NOT under private insurance. It is under the "Insurance" tab and "Public" sub-tab. In the "Medicare Part D" field, you will use the drop-down arrow to indicate that the benefit is "active". Once it is listed as active, other fields will appear to allow you to enter in the company/carrier name and ID number. To enter the carrier, go to the "Medicare Part D Carrier" field and click on the box on the right side of the field to select the appropriate company. Type in the Medicare Part D ID number.*

☐ Yes ☐ No

Company Name: _____ ID#_____ Copy in file? ☐Yes ☐ No

Dental Care? ☐ Yes ☐No *Under the "Insurance" tab, then go to the "Private" sub-tab. Use the drop-down arrow on the right side of the field to select the appropriate category to indicate if the client has "active" dental insurance coverage. Once listed as active, additional fields will show up to be able to enter the rest of the dental insurance information. To enter the company name, click on the "Private Dental Carrier" field. Then click on the box on the right side of the field to select the appropriate company name. Type in the ID number in the corresponding field.*

If yes, Company Name: _____ ID#_____ Copy in file? ☐Yes ☐ No

- ***Client may be eligible for one of the SC ADAP Insurance Programs, which will assist the client with either or both the cost of the premium(s) and/or out-of-pocket costs for prescriptions. See "SC AIDS Drug Assistance Program Technical Assistance Guidelines" for eligibility criteria and enrollment procedures.***
- ***Be sure to remind client to notify you in advance if he/she is in danger of losing coverage.***

SSI / SSDI

Does client receive Social Security benefits at this time? ☐ Yes ☐No
Was this client applied for Social Security benefits? ☐ Yes ☐No
If client was applied to Social Security: Date Applied:_____ Date Effective (If Applicable):_____
Date Denied (If Applicable):_____ Reason for Denial:_____

***MEDICAID**

Does client currently have Medicaid? ☐ Yes ☐ No **Medicaid ID #** _____ **Copy of card in file?** ☐ Yes ☐ No
If yes,
Is the client on the CLTC Medicaid Waiver program? ☐ Yes ☐ No
Is this a Medicaid Managed Care Organization/Plan? ☐ Yes ☐ No **If yes, which company?** _____
What is the Medicaid Benefit Level? ☐ Comprehensive Coverage ☐ Emergency Svcs. Only ☐ Family Planning Only
Under the "Insurance" tab, go to the "Public" sub-tab. First go to the "Medicaid Status" field and indicate if the client's Medicaid is "active" or not. Once listed as active, additional fields will show up to allow you to enter the rest of the information. For Medicaid Managed Care Organizations to be entered, select the "Medicaid MCO" field and use the drop-down arrow on the right side of the field to select the appropriate company. Type in the Medicaid ID into the corresponding field. Fill in the "Medicaid Benefit Level" field and use the drop-down arrow on the right side of the field to select the appropriate category. To indicate if the client is on the Medicaid-CLTC waiver, use the "Medicaid Waiver-CLTC- Status" field and use the drop-down arrow on the right to select the appropriate category.

- **If no, does client meet Medicaid Program eligibility criteria**? ☐ Yes ☐ No
- **If yes, was client applied to the Medicaid Program?** ☐Yes ☐ No
- **If client was applied to Medicaid, Date Applied**: _____ **Date Effective (If applicable):**_____
  Date Denied (If Applicable): _____

If client was applied to Medicaid, you must obtain and file a copy of the Medicaid application.

If client was not applied to Medicaid, indicate all applicable reasons from the list below:
☐ Does not meet disability criteria/Not disabled
☐ Disabled, but does not meet income criteria ($817/Individual and/or $1100 Couple)

☐ Not Custodial Parent
☐ Disabled, but does not qualify for CLTC-HIV waiver Program
☐ Not a US Citizen
☐ Does not have SSI
☐ Not eligible for Medicaid – ABD (Aged, Blind or Disabled) Program

***MEDICARE**

Under the "Insurance" tab, then go to the "Public" sub-tab. Use the drop-down arrow on the right side of the corresponding Medicare fields (A,B, C, D, etc) to indicate if the benefit is "active" or not. See above under the private insurance section for more detailed information on how to enter in Medicare Part D information.

Is client currently enrolled in one or more of the following Medicare Benefit Programs: ☐Yes ☐ No
If yes, **check all that apply:**

☐ Medicare Part A only (no cost to the client and only covers in-patient hospital costs)
☐ Medicare Part B (Medicare program that client pays premium for coverage of medical visits but offers no Rx coverage).
☐ Medicare Part B - SLMB (Medicare program which waives premiums for Medicare Part B and enrolls client, without application, for Part D – Full Low Income Subsidy.)
☐ Medicare – Part D with no subsidy (Medicare program to cover Rxs like a private insurance plan; Client may still be eligible for ADAP services)
☐ Medicare – Part D Low Income Subsidy (Individual income <$13,315 and Couple <$25,035 annually***2008*) (**Client is not eligible for ADAP services.)
☐ Medicare – Part D – GAPS Program (Medicare program in which client 65 and older with an Individual Income <$19, 14- and Couple <$25,660 receive continuation of coverage during the "Doughnut Hole")

****Important: Clients 65 and older who meet the income criteria for Full Low Income Subsidy should apply to FLIS before applying to GAPS Program***.

Does client meet Medicare Program eligibility criteria? ☐ Yes ☐No

- **If no, is the client disabled but hasn't met the 2 year wait time for Medicare eligibility?** ☐ Yes ☐No
- **If yes, when will client be eligible to sign up for Medicare benefits? _____**

***PAYMENT SOURCE (PLEASE LIST ALL THAT APPLY)**

Under the "Insurance" tab, then go to the "Public" sub-tab. Use the drop-down arrow on the right side of the "Primary Medical Payment Source" to select the ONE payment source that is primary. To do this, you must rank the payment sources that the client has if it is more than one. Private insurance is always first; next is Medicare; third is Medicaid; and last is always Uninsured. For example if a client has Medicare and Medicaid, then Medicare will be primary because it must be used first.

☐ Private Insurance ☐ Other Public: Medicare, VA ☐ Medicaid ☐ Uninsured

***SC AIDS DRUG ASSISTANCE PROGRAM (ADAP)**

(ADAP includes: ADAP Direct Dispensing, ADAP Insurance Co-payment Program, and ADAP Health Insurance Continuation)

Is client currently on ADAP? *Under the "Benefits" tab. Use the drop-down arrow to select "yes" or "no" in the corresponding field. This field only appears after you have entered "yes" that the client has ever been on ADAP.*

☐ Yes ☐No **If yes, which program(s):**_____

If "No" has client ever been on ADAP? *Under the "Benefits" tab. Use the drop-down arrow to select "yes" or "no" in the corresponding field.*

☐ Yes ☐No
If yes, Was the client terminated due to noncompliance? ☐ Yes ☐No

****Other ADAP instructions and information*:**

- If client is currently enrolled in ADAP but was not enrolled by your agency, complete the "ADAP Information for Release" form or valid agency Authorization/Release with client's signature and submit it

to ADAP. This step will allow ADAP staff to discuss client with you and will release information in Provide)

- If "Yes" to either ADAP question, create an Informed Consent in Provide to ADAP Enrollment.

If completing an ADAP Application/Re-certification, verify the following checklist items are met: Detailed enrollment procedures and eligibility criteria are documented in the SC ADAP Guidelines.

- Income documentation must be submitted with ADAP Application/Re-certification.

Documentation can include one of the following:

  - Recent pay stub indicating gross pay for that period (Note Pay Period if not indicated)
  - IRS Documents such as W-2 Form or Income Tax Return
  - Signed Employer Statement including Employer Name, Date, Position & Phone Number (Should be on company letterhead)
  - Earnings Statement from Social Security Administration or Social Security Award Letter
  - For Non-US Citizens living in SC, submit an "ADAP Income Statement for Undocumented Persons Living in SC".
  - For applicants with $0 income or unreported income, submit from the Social Security Administration, the Employment Security Commission, or the Internal Revenue Service. Self-certification of income is no longer acceptable.

- Create an electronic "Informed consent" to South Carolina DHEC AIDS Drug Assistance Program – ADAP Enrollment.
- Complete ALL fields on the "ADAP Application", attach a copy of the front and back of the insurance card.
- If completing a "SC ADAP Insurance Application", attach a copy of the front and back of the insurance card.
- If applying for the SC Health Insurance Continuation Program, attach documentation/verification that Insurance Premium amount requested is for Medical and Prescription coverage only and for the client only (not family members). For example, a client's total health benefit premium may include coverage for dental services. Be sure to indicate on the documentation what amount of the total is for health and prescription coverage.

Ways to avoid application/re-certification processing delays:

- Submit up-to-date application/re-certification form(s). To download form(s), brochure or guidelines: http://www.scdhec.gov/health/disease/stdhiv/adap.htm
- Fax documents to ADAP at (803) 896-6252 for Central Pharmacy and (803) 898-7683 for Insurance assistance. If faxing, you do not need to mail original document to ADAP.

*** These instructions are subject to change as ADAP applications and enrollments are automated in the PE system.**

OTHER PRESCRIPTION ASSISTANCE PROGRAMS

Under the "Benefits" tab. Go to the bottom of the page where there is a box under a field called "Program Enrollment Records". Click on the drop-down arrow on the right side of the "Add" button and select "Prescription Assistance Program". Once inside the record, complete the information for: the "Status" using the drop-down arrow on the right side of the field; the "Pharmaceutical Company" name by clicking on the box on the right side of the field and selecting the appropriate company; Select the "Enrolled Drug(s)"by clicking the box on the right side of the field and selecting the appropriate one(s); type in the "Date Enrolled"; type in the "Date of Next Review". Then close and save the record.

Does client need additional assistance for prescriptions while waiting for a pending application to one of the above mentioned prescription coverage or benefit programs? ☐ Yes ☐ No

Is the client ineligible for prescription coverage benefits? ☐ Yes ☐ No

OTHER BENEFITS

Client ID: _____

Is the client currently receiving food stamp benefits? *Under the "Benefits" tab. Use the drop-down arrow to select the appropriate category.*

☐ Yes (active) ☐ Not eligible ☐ Applied ☐ Not interested/needed

Is the client receiving WIC benefits? *Under the "Benefits" tab. Use the drop-down arrow to select the appropriate category.*

☐ Yes (active) ☐ Not eligible ☐ Applied ☐ Not interested/needed

Does the client need assistance applying for other compassionate care/indigent care programs related to medical needs?

☐Yes ☐No **If yes, explain:** _____

_____

Date: _____ Name of Individual Completing Form: _____

Signature of Individual Completing Form: _____